Date:_____

NEW PATIENT INFORMATION

Please print and complete all information.

Name:_____ Date of Birth:_____ M / F

Address:_____ City:_____ State:_____ Zip:_____

Day Phone:_____ Evening Phone:_____ Fax:_____

Email:_____

Employer's Name/Address:_____ Occupation: _____

_____

Referred by:_____

Are you currently under the supervision of a medical doctor? Yes / No

Physician's Name & Phone Number:_____

Is this your first acupuncture treatment? Yes / No If yes, reason for acupuncture: _____

Family History	IF LIVING		IF DECEASED	
		HEALTH	DEATH AGE	CAUSE OF DEATH
	AGE	Good Fair Poor		
Father				
Mother				
Sibling (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐ Partner ☐				
Children (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Have you or any blood relatives had any of these conditions?							
	Yes	No	Relationship		Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Kidney Disease			
Allergies				Leukemia			
Anemia				Mental Disorders			
Alcoholism				Migraine			
Bleeding Tend.				Nervous Breakdown			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease				Other (please list)			

HABITS Daily consumption

Do you smoke? *Y / N* _____packs

Drink coffee? *Y / N* _____cups

Drink alcohol? *Y / N* _____oz

Surgeries you have had: Year

_____

_____

_____

_____

List allergies (including drugs): _____

_____

_____

Medications and supplements currently taking: _____

_____

_____

_____

_____

Illness requiring hospitalization: *Year*

_____

_____

_____

Illness NOT requiring hospitalization: *Year*

_____

_____

_____

Describe any serious injuries or accidents: _____

_____

_____

Please check all that apply:

Fatigue _____

Coughing/ wheezing _____

Stuffy/ runny nose _____

Sore throat _____

Bleeding gums _____

Bad taste in mouth _____

Pain in calves when walking _____

Convulsions _____

Undigested food in stool _____

Mucous in stool _____

Blood in urine _____

Kidney stones _____

Do you exercise regularly? *Y / N* How often (*Days/ hours per week*) _____

Type of exercise? _____

Describe any injuries: _____

WOMEN ONLY - Please mark all that apply:

Are you currently Pregnant? *Y / N / Maybe*

If yes, how many months? _____

Miscarriage? *Y / N* How many?_____

Number of children born alive? _____

Number of still births? _____

Yeast infections: *Y / N* *frequency*: _____

Do you still have regular monthly periods? *Y / N* Date of last period? _____

Number of days of period _____ Length of cycle _____ Bleeding between periods? *Y / N*

Clots: *Y / N* Bleeding color: *dark* ____ *bright* ____ *light* ____ *deep red* ____ *other:* _____

Flow: *profuse / scanty / thin / thick / spotting* Used birth control? _____ *dates:* _____

For the following, please use *B if before, D if during or A if after period:* *tender breasts* _____

bloating ____ *mood swings* ____ *cramps* ____ *Pain: sharp* ____ *dull* ____ *Other:* _____

Vaginal discharge: white / yellow / green / red / brown / thick / thin / sticky / foul odor / profuse

MEN ONLY - Please check all that apply:

Loss of sexual activity? _____ Treatment for genitals? _____ Prostate issues? _____ Discharge from penis? _____ Hernia (rupture)? _____

Other? _____

Date: _____

Patient Name: _____

Main Complaint: _____

(include duration, frequency, severity, location, and character – ex: Cough and constant high fever with dull chest pain for 2 days.)

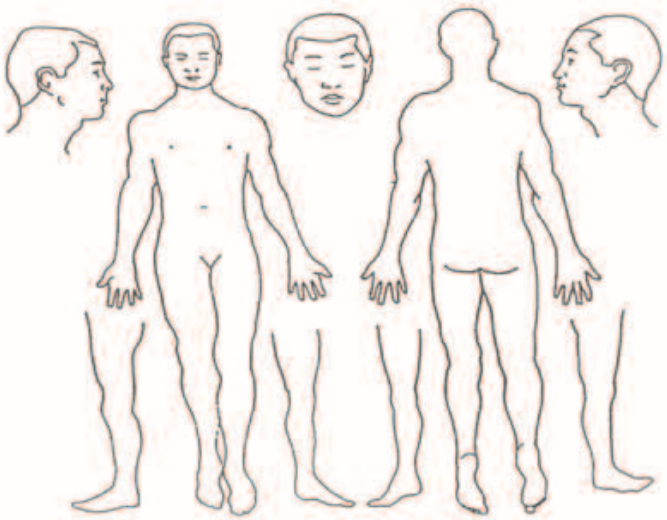
Other Complaints: _____

Outcome of relevant tests: _____

Please mark all applicable items below. If you need to describe detailed information for any item, use the back of the paper with item reference number. Feel free to leave a question blank if you do not know the answer. This form will be discussed during your first visit with Gail.

1. **Body**: *cold / warm / chills / fever*
   Hands: *warm / cold* **Feet**: *warm / cold*
   Chills and fever: *alternating / simultaneous*
2. **Sweating**: *none / profuse / spontaneous / night*
   Location: _____
3. **Pain**: *mild / moderate / severe / excruciating*
   Triggers/relieves: _____
   Level (1-10); 10 is severe: _____
   Quality: *sharp / dull / stabbing / aching / pulling / cold / burning / heavy / other:* _____

Mark areas of pain or distress on the diagram:



4. **Dizziness**: *occasional / frequent*
5. **Chest**: *tight / palpitations / shortness of breath*
6. **Abdomen**: *bloating / distention / acid reflux / gas / heartburn / pain / nausea / vomiting*
7. *tingling / numbness* Location:
8. **Eyes**: *pain / itching / redness / swelling / dry / swelling / tearing / secretion / blurred vision / photophobia / floaters (one eye / both eyes)*
9. **Ears**: *hearing loss / ringing (one ear / both ears)*
10. **Thirst**: *yes / no* **Desire to drink**: *yes / no*
    What do you drink and amount: _____
    _____
11. *no appetite / overeats / hungry & no desire to eat*
    Preferences: *sweet / spicy / sour / salty / bitter*
    What foods do you eat: _____
    _____
    _____
12. **Recent weight**: *gain / loss* # of lbs: _____
13. **Stools**: *dry / small / soft / watery / constipation / diarrhea / foul odor / pus or blood*
14. **Urine**: *scanty / excessive / frequent / night time / incontinence / urgent / painful / difficult / cloudy / odor / yellow / pale / bright / clear / dark / reddish*
15. **Sleep**: *difficult 1st falling asleep / frequent wakeup difficult falling back asleep / restless / many dreams vivid dreams* Average # of hours: _____
16. **Energy level**: *high / low*
    If tired, when? *morning / afternoon / evening*
17. **Mental-Emotional**: *anxiety / irritable / depressed stress / other:* _____
18. **Skin**: *dry / itchy / rash / eczema / acne*
19. **NOTES:**

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I understand that acupuncture treatments may include, but are not limited to, acupuncture, moxibustion, cupping, guasha, electrical stimulation, TDP heat lamps, Tuina, light therapy, nutritional counseling, and herbal medicine. I understand that a licensed acupuncturist will perform these treatments. I understand that the practice of acupuncture and oriental medicine is not an exact science. I acknowledge that no guarantees have been made to me as the result of treatment by **Pilorum Salon & Day Spa** or by its affiliates.

Acupuncture is performed by the insertion of pre-sterilized, single use needles through the skin at various depths and locations. The purpose of acupuncture is to provide relief of presenting symptoms and improved balance of body energies that may lead to prevention, improvement or elimination of the presenting problem. I understand that acupuncture is generally a very safe method of treatment, with a low occurrence of adverse reactions. These possible adverse reactions may include but are not limited to: local bruising, minor bleeding, needle sickness (dizziness, fainting, nausea), pain or discomfort, broken needles, infection from needling in the vicinity of an infection, and possible temporary aggravation of pre-existing symptoms. Rare risks of acupuncture include spontaneous miscarriage, nerve damage, or organ puncture, including lung puncture (pneumothorax). To minimize any adverse reactions, I understand that I should not make significant movements while the needles are being inserted, retained, or removed.

I understand that guasha and cupping are techniques intended to induce minor bruising which may last from 1-5 days. Although unsightly, these bruises are normally not painful. As with any type of heat, I understand there is a risk of burns and/or scarring from moxibustion and TDP heat lamps. I understand the use of herbs may cause gastro-intestinal upset. I understand that it is my responsibility to notify my practitioner if I have any adverse reactions from my treatment.

I understand that it is my responsibility to notify my practitioner, ***prior*** to treatment, if I am pregnant, have bleeding disorders or a pacemaker, or have any other medical conditions that may interfere with my treatment.

I understand that acupuncture is not a replacement for diagnostic medical procedures. An acupuncturist does not diagnose according to standard medical practice, nor should a “Chinese Diagnosis” be considered a replacement for standard medical evaluation or testing. If you have any concerns about what may be causing your symptoms, you must see a medical doctor.

I understand that **Pilorum Salon & Day Spa** and its affiliates may record medical and other information concerning my treatment in electronic and/or other physical form. I understand that if I have any questions regarding my treatment, I should ask a staff member at **Pilorum Salon & Day Spa**. I understand that while this document describes the major risks of treatment other side effects and risks may occur. I am aware that I have a right and freedom to refuse any form of treatment or stop any treatment at any time, for any reason. I, hereby release **Pilorum Salon & Day Spa** and its affiliates from any and all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I have carefully read and understand all the above information, I am fully aware of what I am signing and I do hereby voluntarily give my permission and consent for treatment.

Print Patient Name _____ Date _____

Signature (Patient or Legal Guardian, if minor) _____ Relationship of guardian (if applicable) _____

Pilourm Salon & Day Spa

This Mutual Arbitration Agreement constitutes an integral part of a contract for acupuncture service by and between Pilorum Salon & Spa, who has agreed to be bound hereunder, and the Patient:

1. Any and all claims and disputes between the parties, as to whether any services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes, shall be submitted to arbitration in accordance with federal or Illinois law, and not by a lawsuit or resort to court process except as provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within 30 days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within 30 days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. The award in the arbitration proceeding shall be final and binding on the parties.

3. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

4. Such arbitration shall be in accordance with the current Commercial Arbitration Rules of the American Arbitration Association. This agreement shall apply to legal claim or civil action connected with this service against and practitioner who has agreed to be bound by this provision. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

5. The execution of this agreement shall not be a precondition of furnishing service by the practitioner, and this agreement may be rescinded by written notice from the Patient or Patient's representative to the practitioner within 30 days of signature.

6. This Mutual Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

7. Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency services) patient should initial here:_____.

If any provision of this arbitration agreement is determined to be invalid or unenforceable, the remaining provisions shall remain in full force.

NOTICE: By signing this Contract you are agreeing to have any issue of malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.

_____	_____	_____
Patient/ Parent/ Guardian Signature	If not Patient, indicate relationship	Date

Copies of this document are available upon request.